

PROBLEMS AND CHALLENGES OF SCHOOL HEALTH NURSING IN AKWA IBOM AND CROSS RIVER STATES, NIGERIA

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ABSTRACT

Purpose: This study evaluated the problems and challenges associated with school nursing in Cross River and Akwa Ibom States of Nigeria in terms of coverage, services rendered, adequacy of equipments and supplies, and involvement of other relevant professionals in school health programmes.

Materials and methods: A descriptive design was adopted, and sixty schools were randomly selected from the two states. In each school, one nurse was conveniently selected to give a total of sixty respondents from a population of 171 school nurses from both states. Rustia's school health promotion model guided the study. Validated questionnaire, interviews and review of records were the instruments for data collection. Research questions were analyzed using frequencies and percentages while the Pearson Moment Correlation Coefficient Statistics was used to test the hypotheses determined at a significant level of 0.05.

Results: Results showed low coverage of school health programme in Cross River (3%) and Akwa Ibom (7.2%) states. The scopes of the practice were limited to treatment of minor ailments (100%), referral services (81.7%) health education (41.7%) and first aid (16.7%). Only (18.3%) of the respondents were satisfied with equipments available for school health programme. Furthermore, health services provided by the nurses were positively and significantly related to their knowledge of roles ($r=.532$; $df=59$; $p<0.05$) but not on availability of material resources $r=.023$; $df=59$; $p>0.05$).

Recommendations: It was recommended that school nurses should be well educated on the roles expected of them.

KEYWORDS: Knowledge, Nurses, Practice, Problems, Roles, School-health.

INTRODUCTION

The importance of school health nursing cannot be overemphasized. The health of students at all levels of education is very important if they are to excel in their academic pursuit and develop a good attitude towards a healthy living in the future. Although parents have a great responsibility towards the health of their children, the schools, being the second home of the children also need to take their health seriously.

The general aim of school health programme is the promotion of well adjusted, physically vibrant children that are without preventable defects, but who could imbibe health practices, attitudes and knowledge that will make them to have a high level of well-being and the ability to make the necessary decision that will affect their families' health positively. According to Anderson and Cresswell (2003), the purpose of today's school health programme includes the need to promote, protect and restore the health of school children and staff.

It could be in the recognition of this important concept that Nigeria as a nation has also adopted and made a policy declaration concerning adolescents' health. One objective of the declaration is to provide guidance and service for the promotion of adolescents' health (Federal Ministry of Health, 2001). Additionally, health risks among adolescents are being brought about by recent trends (e.g. HIV/AIDS) in the wider society and family. Nurses, especially in the more developed nations have responded to these changes through the development of school nursing with focus on health screening, case management and health counseling to mention but a few. In these past

years, as opined by Stanhope and Lancaster (1996), school nursing has become more comprehensive in the more developed nations to meet the health care needs of the students. However, with the increasing need for school health nursing as observed in Akwa Ibom and Cross River States, this aspect of care is still in the rudimentary stage and completely lacking in many areas of the states.

Statement of the problem

The gruesome picture of the health of our children especially in the area of reproductive health in Nigeria can be attributed to poorly developed school health services. According to Fajewonyomi and Afolabi (1999) school health services had been solely limited to posting a few nurses to a few urban secondary schools with their roles not properly defined. The above situation has not improved over the years and similarly gives a true picture of the current situation in Cross River and Akwa Ibom States, thus calling for a new direction for school health programme. For such direction, pertinent questions need to be answered culminating into the study aimed at identifying the problems and challenges of school health nursing in Akwa Ibom and Cross Rivers, with attention on what should be the focus in the resolution of identified problems.

Specifically, the study focused on the following objectives:

- 1) Determine the current coverage of school health programmes within the two states;
- 2) Determine the services rendered by the school nurses in their various schools;
- 3) Determine the respondents' assessment of adequacy of equipments and supplies provided for school health programmes;
- 4) Identify other professionals that were performing school health duties;
- 5) Ascertain the problems encountered by the nurses in the practice of school health programmes;
- 6) Determine if there was significant relationship between nurses' knowledge of roles for school health programmes and health services rendered by them;
- 7) Ascertain the relationship between nurses' level of satisfaction with equipments and supplies provided for school health programmes and the services rendered by them.

Significance of the study

This study will help to identify the current state of school health services and areas that require interventions, so that the expected goals of school health programmes will be achieved. The findings will assist in providing guidance on needed policies; directions that planning should go and strategies to be put in place for successful provision of school health services.

Research questions

The study provided answers to the following research questions:

1. What is the current coverage of school health programme?
2. What are the services rendered by the school nurses in their various schools?
3. What are the respondents' assessment of adequacy of equipments and supplies provided for school health nursing programmes?
4. Who are the other professionals performing school health programmes?
5. What are the problems encountered by the nurses in the practice of school health?
6. What is the relationship between nurses' knowledge of roles for school health programmes and services rendered by them?
7. What is the relationship between nurses' level of satisfaction with equipments and supplies provided for school health programmes and the services rendered by them?

Hypotheses

Two null hypotheses were tested at 0.05 levels of significance:

- Ho 1: Nurses' knowledge of roles for the school health programmes has no significant relationship with the school health services rendered by them
- Ho 2: Nurses' level of satisfaction with equipments and supplies provided for school health programmes has no significant relationship with the school health services rendered by them.

Literature review

Ademuwagun and Oduntan (2000) asserted that school health is an integral part of community health and it mainly refers to all the health activities and measures that are carried out within the community to promote and protect the health of children of school age and school personnel. Similarly, the school health programmes are viewed as the health programme in the school setting that takes care of the health needs of both staff and more importantly that of the students (Moronkola, 2003). Moronkola further clarified that school health programmes are both educational and health directed, aimed at meeting the needs of students and staff and laying good foundation for their future health status with the support of the home, community and the government.

A close look at the definitions reveal that the school health programme embraces the concept of health as focusing on primary, secondary and tertiary prevention of physical, emotional and or social health problems. For this reason, it would involve the five major activities, which are health promotion, disease prevention, curative care, disability limitation and rehabilitation. As a community health concept, school health directs attention to health care more often provided outside the therapeutic environment and could equally fit into Kioussbusch's (2004) description of health promotion as a determinant based process of social change, contributing to the goal of human development, building on many disciplines and applying interdisciplinary knowledge in a professional, methodical and creative way.

Furthermore, Ajala (2003) described the school health programme as a combination of various procedures and activities designed to protect and promote the well being of students, school administrators and teachers. When viewed in this perspective, school health as a concept defines an area of practice, which is wide in scope, embracing school health education, school health services and healthful school environment (Udoh, 1999). Although the scope of school health programme is well identified with strategies for providing the services clearly documented in literature, practice is often limited to curative care in some cases and lack of any programme in some other cases also.

The World Health Organization's Expert Committee on Health-Promoting Schools identified five broad barriers to the development of school health programmes. According to Kickbusch, *et al*, (1999), those barriers include: inadequate vision and strategic planning; lack of responsibility and acceptance of programmes; lack of responsibility and accountability; inadequate collaboration and coordination among persons addressing health in schools, and lack of programme infrastructure. Additionally, many schools according to Eke (1998) have no designated facilities with appropriate equipments and supplies that could help in diagnosis, treatment and meeting emergency care and referral services. In his estimation, Nigerians regard schools as only places for academic pursuits, and nothing more, and therefore place minimal priority on school health programmes.

Commenting on the roles of the Nurse in school health programme, Modrein-Talbott (2002) asserted that where school health programmes are well developed, as it is in the more developed nations, the roles of the school nurse vary and include carrying out complex arrays of activities to promote health and prevent diseases within a school community. In her estimation, knowledge of roles could foster appropriate practice although other factors should also come to play. A school nurse who is well educated and able to clearly articulate her roles and functions, and who demonstrates clinical expertise to all members of the school health team is more likely to be used appropriately than one who has trouble defining what it is a school nurse has to offer. Thus, problems could arise where the nurses are unaware of their expected roles on account of limited training. According to Modrein-Talbott (2002), the roles of the school nurse include advocacy, case finding, community liaison, consultant, epidemiologist, health counselor, health educator, home visitor, team member and researcher.

Thus in a way, there is currently an extension of school health programmes beyond the classic triad of school health education, school health services and healthful school environment. A confirmation of this could be obtained from the submission made by Resnicow and Allenworth (1999) that with the classic triad, healthy environment, staff wellness and community activities to meet the health needs of pupils or students were often neglected because no one had the designated responsibility for addressing them. For this reason, school health was made more comprehensive by including the School Health Coordinator, physical education, counseling, psychology, social

services, food services, staff wellness and family/community development. This broadened scope of school health programme directs attention to Rustia's (2002) school health promotion model (Fig. 1).

Description of the model

The model clearly identifies the objectives of school health nursing as it fits into the three levels of prevention: primary, secondary and tertiary prevention aimed at meeting the physical, emotional and/or social health problems. Directly below the service objectives are listed specific nursing interventions to achieve the stated objectives. Following directly under the specific nursing interventions are the lists of health outcomes on the family, students, teachers, supportive personnel as well as the community.

Relating the model to school health programmes

The model clearly illustrates the range of interventions used by nurses to promote healthy lives and to improve quality of life in the school setting. It also reflects the comprehensive nature of school nursing and could be used by school nurses as a framework for articulating roles and functions. With the model, it is easy to identify gaps or problems in the effective planning and implementation of school health programmes. The model also provides a tool not only for stating objectives of school health nursing but for implementing and evaluating the impact of school health nursing programmes.

METHODOLOGY

A descriptive research design was used and the target population for the study comprised of the two School Health Nursing Coordinators in the two states (Akwa Ibom and Cross River States), 90 available school nurses in Cross River State and 81 in Akwa Ibom State. This gave a total of 171 nurses who were permanently in the school health system. Out of 28 Secondary Schools with School Health Clinics in Cross River State 23 were selected through simple random sampling technique of balloting. Only seven primary schools had school clinics and all were selected thus giving a total of 30 schools from Cross River State. In Akwa Ibom State where there were 47 secondary schools and 30 primary schools with school clinics, simple random sampling method of balloting was also used to select 15 schools each from both the secondary and primary schools, similarly giving a total of 30 schools from the state. In each of the 60 schools selected from both states, a convenient sampling technique was used to select one respondent, giving a total of 60 respondents out of a total population of 171 from Cross River and Akwa Ibom States.

Data collection involved interviews, review of records and the administration of questionnaire to school health nurses. A-33 items author developed structured and semi-structured questionnaire was used to collect data for the study. Structured and semi-structured questions were used to allow for accurate assessment of their levels of awareness and also their opinions. The questions on knowledge of roles and services rendered by them involved the listing of ten (10) roles and ten (10) services for respondents to identify those applicable to them. Each correct identification of roles attracted one point with a maximum of 10 points (mean=6). Validation of the instruments involved the use of Content Validity Index (CVI) with a score of 0.91. To test for the reliability of the instrument, a test-retest method was used whereby a sample of ten respondents from schools not included in the study were administered the questionnaire on two consecutive occasions at the interval of two weeks. A computation of both results gave a correlation coefficient of 0.89.

The questionnaires were administered through personal face-to-face interaction with the respondents in the various schools and on the spot completion and retrieval of questionnaire. This data collection method ensured 100% return rate.

Method of data analysis

Socio-economic data and research questions employed descriptive statistics of frequencies and percentages while the Pearson Moment Correlation Coefficient Statistics was used to test the two generated hypotheses. For satisfaction with equipments and supplies, Likert scale questions were used and scores allotted were based on their level of satisfaction. Those who had the mean score of 3.2 or higher were grouped as satisfied, while others who had a lower mean score below 3.2 were grouped as not satisfied with available equipments and supplies for school health programmes.

RESULTS

Table 1: Socio-demographic data of respondents (n=60)

Results from Socio-demographic data presented in Table 1 shows that 53 (88.3%) of the respondents were females while 7 (11.7%) were males. Their age range was between 25 to 49 years with the highest number 21 (35%) occupying the age range of 35-38 years. For professional education, one (1.7%) was a registered midwife, 4 (6.7%) were registered nurses, 20 (33.3%) held the registered nurse/registered midwife certificates, 29 (48.3%) were Community Health Officers, while six (10%) had the Bachelor of Science degree. On their years of nursing experience, majority, 28 (46.7%) had worked for 16 – 20 years while those who worked for the least number of years: 6 -10 years, were 2 (3.3%).

The current coverage of school health programme

Table 2 shows that out of two hundred and twenty six (226) secondary schools in Cross River State, twenty-eight (28) had school clinics with 21 located in the urban and seven located in the rural areas. Out of nine hundred and forty two (942) Nursery/Primary Schools, seven (7) had school clinics. All the seven Primary School Clinics were situated in the urban areas. On the distribution of nurses, 51 were in urban Secondary Schools, 20 in the rural while 19 were in urban nursery/primary schools (Ministry of Health Records, Calabar, Nigeria; (2004), Etifit, (2004). This translates to a total coverage of 35 out of 1168 schools or 3% coverage in Cross River State.

Distribution of school clinics and nurses in Akwa Ibom State

Table 3 shows that from a total of two hundred and forty three (243) secondary schools, forty-seven (47) had school clinics while out of eight hundred and thirty (830) Nurseries/Primary Schools, thirty (30) had school clinics (Ministry of Health, Uyo, Nigeria, 2004). This gives a total coverage of 77 out of 1073 schools or 7.2% coverage. 38 of the secondary school clinics were located in the urban areas while nine were in the rural areas. Similarly 26 Primary School clinics were in the urban areas while four were in the rural areas. On the distribution of nurses, 40 were in the urban Secondary schools, ten (10) were in the rural secondary schools, 27 were in the urban primary schools while 4 were in the rural primary schools.

Results from interview:

On the reasons why most of the schools did not have school health programmes. It was identified that in both states, availability of school clinics and the distribution of school nurses were limited to schools who had made their request and who could meet the given criteria for such consideration. These criteria include the provision of accommodation for the school clinic, regular provision of essential drugs and basic equipments. Additionally, apart from being unable to meet these basic requirements, the information or awareness was lacking in many schools. There was also the problem of dearth of qualified nurses for the school health programme (Etifit, 2004; Umoren, 2004).

Health services rendered by school nurses

The questions on health services rendered comprised of ten listed services. Table 4 shows that all the 60 (100%) respondents identified treatment of minor ailments as the service they rendered. Referral was identified by 49 (81.7%) of the respondents, 25 (41.7%) identified health education, while only 10 (16.7%) indicated first aid as the service they rendered. All other six (6) services were unidentified as the services rendered by the respondents. Scores were only allotted based on services identified.

Respondents' satisfaction with equipments and supplies: Respondents' satisfaction with equipments and supplies were measured with five (5) items graded on a four-point Likert type questions. Scores were allotted based on the level of satisfaction and following statistical analysis, respondents who scored 12.5 and above were grouped as satisfied while others who scored below 12.5 were grouped as not satisfied with equipments and supplies as presented in Table 5. Table 5 indicates that 18 (30%) of the respondents viewed the equipments and supplies provided for school health programme as adequate while 42 (70%) assessed it as not adequate and were therefore not satisfied.

Professionals that are performing school health duties

Table 6 shows respondents' list of other professionals who also perform school health services. Teachers made up 22 (36.7%) of the professionals, health assistants were identified by 49 (81.7%) of the respondents, nutritionists contributed three (5%) of the professionals, while physicians were mentioned by six (10%) of the respondents.

Problems encountered by nurses in the delivery of school health services

Referring to Table 7, it is observed that the majority of respondents 52 (86.7%) identified lack of equipments and facilities as the problem they encounter. This was followed by lack of drugs 49 (81.7%), poor staffing 46 (76.7%) and poor accommodation 43 (71.7%). Lack of transport for referral was identified by 42 (70.0%) of the respondents while 16 (26.7%) pointed at lack of co-operation from school heads. Only six (10%) of the respondents identified poor feeding of students as one of the problems.

Research hypotheses

For the first hypothesis, the result of the Pearson Product Moment Correlation Analysis in Table 8 shows a mean score of 3.20 on respondents' knowledge of roles. Furthermore, the relationship between nurses' knowledge of roles for school health services and the health services provided by them was positive, moderately strong and significant ($r=.532$, $df=59$; $p<0.05$). The null hypothesis of no relationship was therefore rejected. This implies that increase in the knowledge of roles was accompanied by increase on health services provided.

With hypothesis 2, presented in Table 9, the result of the Pearson Product Moment Correlation Coefficient Analysis shows that the relationship between nurses' level of satisfaction with equipments and supplies and the school services rendered by them was positive but very weak and not significant ($r=.023$; $df=59$; $p>0.05$). The null hypothesis of no significant relationship was therefore not rejected.

DISCUSSION

Findings from the study revealed that the current coverage of the school health programme was low. A situation where only 3% of the schools are covered as in Cross River State or 7.2% as in Akwa Ibom State is unsatisfactory. For any future national development, great attention must be paid to adolescents' development and a sound foundation should be laid for their future health decisions as it is done in the more developed nations.

A good proportion of the respondents in this study were not satisfied with the equipments and supplies provided for school health services. A situation where essential materials and facilities are lacking could give an indication that all nursing activities either curative or preventive could only be carried out with great difficulties and on the other hand may not be performed at all. This does not provide an enabling environment for quality care or smooth running of activities relevant to school health programmes.

When the respondents were asked to list all the services they rendered, their lists were all limited to four areas of care out of ten (10) roles. All the sixty (60) respondents identified treatment of minor ailments, followed by referral while health education, which is an important component of school health programme was only listed by less than half of the respondents. With the general aim of school health programmes as the promotion of well adjusted, physically vibrant children that are without preventable health problems, it could be said that school health as currently practiced is likely to make limited impact in the lives of our students.

School health interventions should cover primary, secondary and tertiary prevention of physical, emotional and/or social health problems as identified in Rustia's (2002) conceptual model. On other professionals performing school health programmes, the finding indicating inadequate team approach corroborates Kickbusch, et al., (1999) assertion of inadequate collaboration and coordination among persons who should address health issues in schools. Additionally, although it is generally recognized that the nurses have a significant contribution to make in all aspects of school health, no one discipline can meet the needs of all the school-age children. Team cooperation and collaboration are essential for children to receive the health services they deserve. This finding is in line with the observation of Eke (1998) that many schools have no designated facilities with appropriate equipments and supplies that could help in diagnosis, treatment and meeting emergency care and referral services. The findings from this study also corroborate Fajewonyomi and Afolabi's (1999) observation that a few nurses are usually posted to a few

urban schools with their roles not clearly defined and no supervision maintained. It was also very revealing to identify that the relationship between nurses' knowledge of roles for the school health programmes and the health services rendered by them was positive and significant. This finding is not surprising since one would expect that individuals could only practice roles when they possess knowledge and skills to perform such roles. This result is an indication that availability of resources alone is not enough to determine practice. The nurses themselves have to be knowledgeable about the roles expected of a school nurse.

The statistical test, which showed non-significant relationship between satisfaction with equipments and supplies for school health services and the services rendered by the respondents, is rather surprising. It goes to confirm that the availability or lack of resources alone is not enough to determine practice. This shortcoming may not be unconnected with the problems identified by the W.H.O. (Kickbusch, *et al.*, 1999). The W.H.O. Expert Committee asserted that factors such as inadequate vision and strategic planning, inadequate understanding and acceptance of programmes, lack of responsibility and accountability, inadequate collaboration and coordination among persons who should address school health issues, and lack of programme infrastructure could all affect practice. There is therefore a need for advocacy for improved focus on school health programmes.

CONCLUSION/RECOMMENDATIONS

- i. Coverage of school health programmes should be extended to reach a wider proportion of schools. If specialized nursing services whereby school nurses are posted to schools are not practicable on account of dearth of nurses, generalized nursing services should be encouraged, whereby nurses working in primary health care centres cover the schools nearest to them until adequate number of nurses are trained to take up the duty. Similarly, functional health programmes including provision of health education machinery should be set up in both urban and rural schools. For the resolution of problems identified in this study, Government at the Federal, State and Local levels should review, articulate properly and enforce identified roles aimed at meeting the health needs of school children. This requires appropriate financial investment and improvement of all resources required for school health. Provision of needed facilities, equipments and supplies should not only be the concern of the school principals.
- ii. For improved coverage and collaboration among care providers, each school should be provided with a health team. The health team in collaboration with the service providers could therefore plan for the services to avoid duplications or programmes and non-provision of essential services. Nurses in schools should be well trained on the roles expected of them. This could be achieved through continued education programmes including well-planned seminars and workshops. Since school health programme is broad based, school health nurses should be system designers. This requires nurses with high academic or specialized preparation in school health. Since this later recommendation cannot be met overnight, it is recommended that workshops on school health nursing be planned and implemented in the states for school health nursing practitioners. Specialized school health nursing certificate course should also be developed for school health nursing just as it is done for ophthalmic nursing, orthopaedic nursing to mention but a few. This is to quickly provide the needed manpower to meet the dearth of this category of professionals. Thereafter, a long-term plan of training school nurses at the University as a matter of necessity could be made and implemented.
- iii. To broaden the scope of practice, Principals/Headmasters and teachers constituting the organization's professional grouping and physicians, dentists and other health workers making up the health providers' grouping should collaborate with each other and with Government representatives/donor agents and families in a very meaningful way to plan and accomplish the identified goals of school health services/programmes.

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Fig. 1: Rustia's School Health Promotion Model (Rustia, 2002)

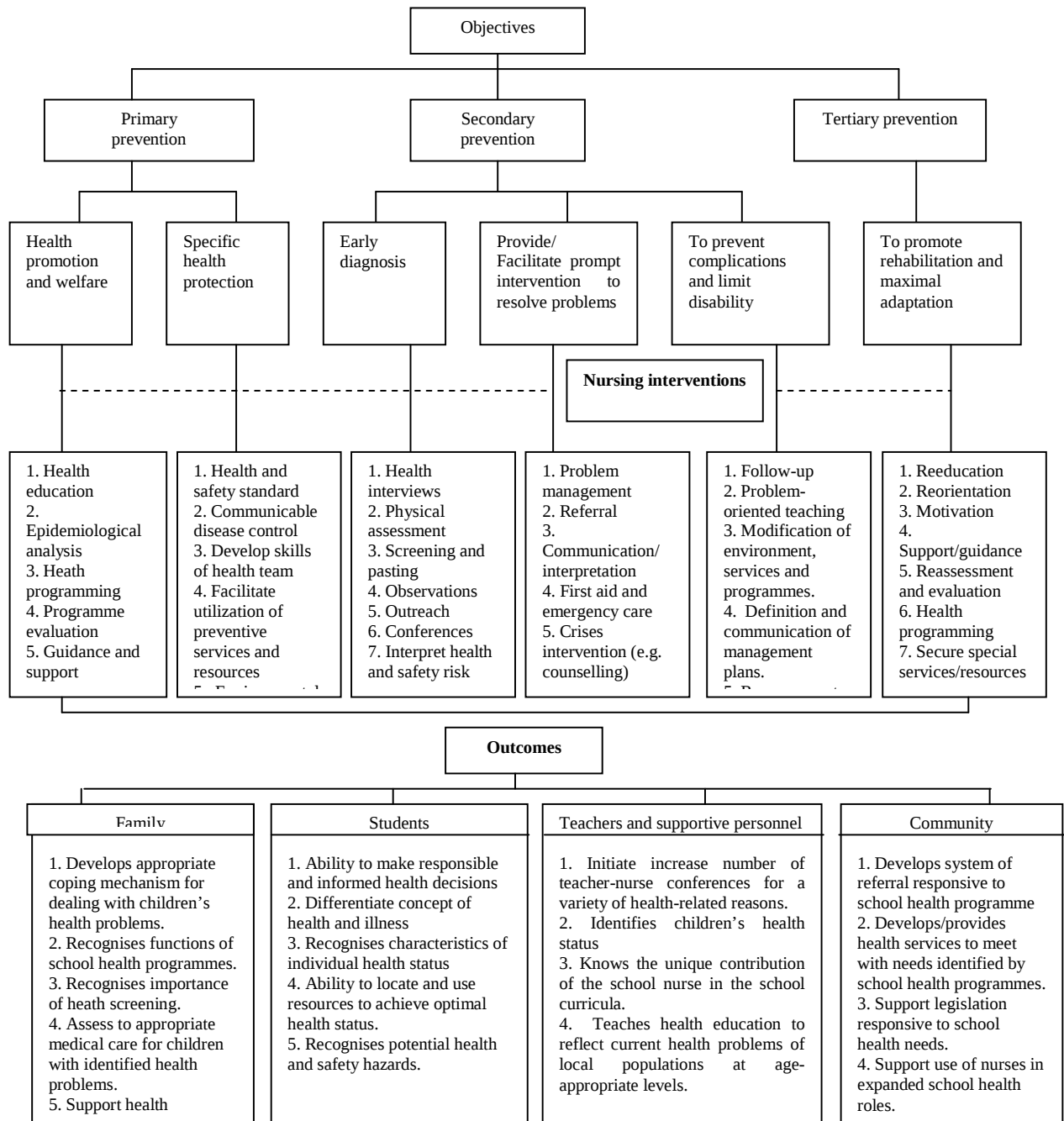


Table 1: Socio-demographic data (n=60)

Variable	Frequency	%
Sex:		
Female	53	88.3
Male	7	11.7
Total	60	100.00
Age in years:		
25-29	3	5
30-34	4	6.7
35-39	21	35
40-44	17	28.3
45-49	15	25
Total	60	100.00
Marital Status:		
Married	54	90.00
Single	6	10
Divorced	-	-
Total	60	100.00
Professional education:		
R.M.	1	1.7
R.N.	4	6.7
R.N./R.M.	20	33.3
CHO	29	48.3
B.Sc	6	10
Total	60	100.00
Years of experience:		
6-10	2	3.3
11-15	11	18.3
16-20	28	46.7
21 years and above	19	31.7
Total	60	100.00
Location of work:		
Urban	47	78.3
Rural	13	21.7
Total	60	100.00

Table 2: Distribution of school clinics and nurses in Cross River State

School location	Secondary school clinics	Primaryschool clinics	Nurses in sec. schools	Nurses in primary schools
Urban	21 (9.3%)	7	51	19
Rural	7 (3.1%)	(.7%)	20	-
	28 (12.4%)	7 (.7%)	71	19

Sec. Schools = 226; Nurseries/primary schools = 942

Table 3: Distribution of school clinics and nurses in Akwa Ibom State

School location	Secondary school clinics	Primary school Clinics	Nurses in sec. schools	Nurses in primary schools
Urban	38 (15.6%)	26 (3.1%)	40 10	27 4
Rural	9 (3.7%)	4 (5%)		
	47 (19.3%)	30 (3.6%)	50	31

Sec. Schools = 243; Nurseries/Primary schools = 830

Table 4: Health services rendered by school nurses (n=60)

Health services	Number of nurses involved	%
First Aid	10	16.7
Treatment of minor ailment	60	100.3
Referral	49	81.7
Health education	25	41.7

Table 5: Respondents' satisfaction with equipments and supplies provided for school health programmes (n=60)

Equipments and supplies	Frequency	%
Satisfied	18	30
Not satisfied	42	70
Total	60	100.00

Table 6: Professionals that are performing school health duties (n=60)

Professionals	Frequency	%
Teachers	22	36.7
Health assistants	49	81.7
Nutritionists	3	5
Physicians	6	10

Table 7: Problems encountered by nurses in the delivery of school health services (n=60)

Problems	Frequency	%
Lack of drugs	49	81.7
Poor accommodation	43	71.7
Lack of equipments/facilities	52	86.7
Poor staffing	46	76.7
Lack of transport for referral	42	70.0
Poor feeding of students	6	10
Lack of cooperation from school heads	16	26.7

Table 8: Relationship between nurses' knowledge of roles for school health programmes and health services rendered

Variables	Mean	Std. deviation	n	r	df	Significant level	Remark
Nurses' knowledge of roles for school health programmes	3.20	.425	60	.532	59	.000*	significant
Health services provided	4.68	2.013	60				

Sig. = Significant at (P<0.05)

Table 9: Relationship between nurses' level of satisfaction with equipments/supplies and school services provided

Variables	Mean	Std. deviation	n	r	df	Significant level	Remark
Nurses' level of satisfaction with equipments and supplies	7.34	4.122	60	.023	59	.083*	Not. Sig.
Health services provided	4.68	2.013	60				

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